Date: [Date]

To: [Surgeon Name]
Facility: [Surgical Center/Hospital Name]
Fax: [Fax Number]

RE: Medical Clearance for Cervical Disc Replacement
Patient Name: [Patient Name]
Date of Birth: [DOB]
Proposed Surgery Date: [Surgery Date]

Dear Dr. [Surgeon Last Name],

I have evaluated [Patient Name] for preoperative medical clearance regarding the scheduled cervical disc replacement. My assessment included a physical examination, review of medical history, and the following diagnostic tests: [List tests, e.g., EKG, blood work, chest X-ray].

Medical History & Observations:
[Briefly list chronic conditions, e.g., Hypertension, Diabetes, etc., or state "None"]

Medication Management:
The patient has been instructed to:

- Stop [Medication Name] on [Date].
- Continue [Medication Name] until the day of surgery.

Clearance Status:
Based on my evaluation, the patient is:
[ ] **Cleared** for surgery without restrictions.
[ ] **Cleared** for surgery with the following recommendations: [Insert recommendations].
[ ] **Not cleared** at this time due to: [Insert reason].

If you have any questions regarding this clearance, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Practice Name/Clinic]